STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 90608-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 18th day of August 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 25, 2008, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on July 2, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 11, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). Rider CBD $1000-P (Community Blue Deductible Requirement for Panel Services) also applies. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On November 16, 2007, the Petitioner underwent a psychiatric interview examination and psychological testing at XXXXX. BCBSM approved $552.12 for this service and applied it to his 2007 panel deductible. On January 11, 2008, the Petitioner had individual psychotherapy at XXXXX. BCBSM approved $118.22 for this service and applied it to the Petitioner's 2008 panel deductible. As a result, the Petitioner incurred $672.34 in out-of-pocket expenses.

The Petitioner appealed BCBSM's decision to apply the total $672.34 approved amount for this care to his 2007 and 2008 deductible requirements. He believes 50% of the approved amounts should have been paid to the provider or his family. BCBSM held a managerial-level conference on April 21, 2008, and issued a final adverse determination dated May 1, 2008.

III
ISSUE

Did BCBSM correctly process the Petitioner's claims for mental health care on November 16, 2007, and January 11, 2008?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that his coverage requires BCBSM to pay 50% of mental health care provided in a physician's office. He argues that the psychiatric evaluation, testing, and psychotherapy were done in a physician's office at XXXXX and therefore should not be subject to the deductible. The Petitioner says there was no way for his family to know that XXXXX is contracted with BCBSM as an outpatient psychiatric facility and not considered to be a physician's office.

The Petitioner's mother said she contacted BCBSM twice by telephone and confirmed that care provided at XXXXX would be covered at 50%. However, when the claims from XXXXX were

processed, BCBSM applied its full approved amount for the Petitioner's care to the deductible, explaining that the care was billed through an outpatient psychiatric facility and not a physician's office.

The Petitioner believes that BCBSM is required to pay 50% of the approved amount for his care because his family was given incorrect information.

BCBSM's Argument

BCBSM says it correctly covered the Petitioner's mental health care at Pine Rest, a panel provider, according to the terms and conditions of the certificate's rider. Rider CBD $1000-P specifically provides that:

> You [the Petitioner] are required to pay the following deductible each calendar year for most covered services provided by panel providers:
>
> - $1,000 for one member

The rider goes on to says that the deductible is not required when covered mental health services are performed in a panel physician's office. However, BCBSM says that XXXXX is an outpatient psychiatric facility, not a physician's office, and so the deductible applies. BCBSM applied $554.12 to the 2007 deductible and $118.22 to the 2008 deductible.

BCBSM does not believe it provided misleading information to the Petitioner's family. BCBSM says that when the Petitioner's mother inquired about care provided by a psychiatrist or a Ph.D. psychologist, no mention was made about care provided by an outpatient psychiatric facility.

BCBSM believes that it processed the Petitioner's claims correctly under the terms of the certificate and rider.

Commissioner's Review

Rider CBD $1000-P indicates that covered services provided in a panel physician's office are not subject to the panel deductible and copayment. However, the Petitioner's mental health care on November 16, 2007, and January 11, 2008, was provided at an outpatient psychiatric facility and not a physician's office.

The Petitioner notes that he received the services in the office of a physician at XXXXX. It is unfortunate that the distinction between a "physician's office" and an office in an outpatient psychiatric facility was not readily apparent to the Petitioner. Nevertheless, it is a distinction that is important because under the certificate BCBSM handles claims billed by facilities differently than claims for care that is billed by a physician for services performed in his/her office. In this case, the care was received from and billed by an outpatient psychiatric facility and was therefore subject to the panel deductible.

The Petitioner's mother believes that she was given misinformation by BCBSM and, by acting in reliance on that information, incurred considerable out-of-pocket costs that she could have avoided. BCBSM disputes her contention, saying that it did not provide incorrect information. This kind of dispute cannot be resolved in a review under the PRIRA.

Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of a factual dispute like the one described by the Petitioner cannot be the basis of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements and witness credibility. Moreover, the Commissioner lacks the authority under PRIRA (which the circuit courts possess) to order relief based on doctrines such as estoppel.

In conclusion, the Commissioner finds that BCBSM has correctly applied the provisions of the Petitioner's certificate and rider when it processed the Petitioner's claims.

V
ORDER

BCBSM's final adverse determination of May 1, 2008, is upheld. BCBSM processed the Petitioner's claims correctly under the terms and conditions of the certificate and its rider.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order

in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.